1, 2005 through December 31, 2011 for patients with commercial or employer-sponsored supplemental Medicare insurance. Bevacizumab claims were excluded if the claim had a diagnosis related to macular degeneration or other eye disease. Claims for both drugs were excluded from the payment analysis if the reimbursed amount was less than $100. All claims were identified as occurring in an office-based setting (OBS), an outpatient hospital setting (OHS) or other setting. **RESULTS:** The percent of bevacizumab claims occurring in OHS increased from 6 to 37% among Medicare claims, and from 15 to 42% among commercial claims from 2005 to 2011. For trastuzumab, the increases were 9 to 33%, and 17 to 37% in Medicare and commercial claims, respectively. Median bevacizumab reimbursement increased 56% ($3000 to $4681) for OBS and 125% ($3438 to $7739) for OHS from 2005 to 2011 in commercial claims. For Medicare claims, the increases were 88% ($2284 to $4284) and 111% (2284 to $4827) for OBS and OHS, respectively. For trastuzumab commercial claims, median reimbursement increased 47% ($2037 to $2996) and 88% ($2749 to $5171) for OBS and OHS; while for Medicare the increases were 68% ($1697 to $2854) and 67% ($1704 to $2838), respectively. **CONCLUSIONS:** The shift in chemotherapy administration from OBS to OHS and related growth in reimbursement for outpatient hospital settings relative to office settings has implications for the growth in cancer costs over the past decade. Further research is warranted to understand the drivers of the shift in location and whether future policies should address reversing the shift.

PCN58

DIRECT COST OF CANCER PATIENTS ON BRAZILIAN HOSPITAL AND MEDICINES (CHEMOTHERAPY AND PALLIATIVE CARE)

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OBJECTIVES: To analyze the cost of care in oncology inpatients in Brazilian private hospitals and their spending on medicine (chemotherapy and palliative care). **METHODS:** We selected patients who consume antineoplastic medicines in Orizon database (16 million lifes) within a 12-month period and analyzed their medical bills, appointments and hospitalizations (direct costs) and also medicines for palliative treatment. **RESULTS:** We identified 1244 patients who consume an annual average of R$ 6,342.51 in outpatient use of anticancer drugs per patient and their medical bills US$30,320.78 in expenses with a mean hospital stay of 4.60 days with 4, 48 consultations per patient to the cost of R$210.56 and the cost of medicines for palliation of R$6,277.16 (regulators of bone metabolism, corticosteroids, antidepressants, anti-inflammatories, diuretics, antiemetics, anticonvulsants, analgesics, vitamins and antispasmodics) **CONCLUSIONS:** The direct costs of cancer patients is not restricted only hospital infusions and their admissions, but also outpatient expenditures such as oral medications and palliative treatments.

PCN59

INCREMENTAL COST OF BRAIN METASTASES AMONG PATIENTS WITH METASTATIC MELANOMA

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OBJECTIVES: The prognosis of melanoma patients with brain metastases is poor, with median overall survival of approximately 4-5 months. This is the first study aiming at quantifying medical resources utilization and direct health care costs associated with brain metastases among metastatic melanoma patients in the U.S. **METHODS:** A retrospective pre-post design was implemented using data from the Truven MarketScan claims database (2000Q1-2011Q3). Patients with ≥1 diagnosis of melanoma (ICD-9-CM: 172-173, 198.2), ≥1 diagnosis of brain metastases (ICD-9-CM: 198.3), and ≥18 years as of the first observed brain metastases diagnosis (index date) were identified. The pre-period was defined as the 6 months prior to the index date and post-period as the period following the index date up to the earliest of 12 months, recorded death, or loss to follow up. All-cause and brain metastasis-related medical resources and health care costs were compared on a per patient per month (PPPM) basis between the pre- and post-periods. **RESULTS:** The study population consisted of 6076 patients; mean (SD) age was 63.4 (13.4) years and 57.6% males. Significant differences were observed between the post- and pre-period in mean all-cause PPPM hospitalizations (0.21 vs. 0.08), emergency department visits (0.12 vs. 0.08), and outpatient visits (4.48 vs. 3.74) (p<.0001 for all). Similar results were found for brain metastasis-related hospitalizations (0.15 vs. 0.04), emergency department visits (0.02 vs. 0.01), and outpatient visits (2.00 vs. 1.17) (p<.0001 for all). Significant post- vs. pre-period differences were also observed in the PPPM all-cause health care costs (total: $14,489 vs. $7,277; inpatient: $6,330 vs. $1,900; outpatient: $6,609 vs. $4,449; p<.0001 for all) and brain metastasis-related costs (total: $6,542 vs. $1,933; inpatient: $2,976 vs. $472; outpatient: $3,451 vs. $1,413; p<.0001 for all). **CONCLUSIONS:** The economic burden associated with brain metastases in melanoma is significant and underscores the need for newer therapies improving outcomes among these patients.

PCN60

CLINICAL CARE PATH AND COSTS ASSOCIATED WITH MANAGING PATIENTS WITH PROLONGED AIR LEAKS AFTER THORACIC LUNG VOLUME REDUCTION SURGERY: A REVIEW OF THE LITERATURE

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OBJECTIVES: Prolonged air leaks (PAL) lasting >5 days occur in up to 50% of all patients undergoing lung volume reduction surgery (LVRS); resulting in increased length of stay (LOS), patient morbidities, and health care costs. We sought to map care path options for the management of PAL following LVRS among emphysematous patients, and to report estimates of associated costs. **METHODS:** Peer-reviewed English language articles from January 2000 – September 2012 were searched using pre-identified terms. A typical care path for a male smoker with emphysema was mapped from diagnosis to removal of chest tube after LVRS. Parameters extracted from the identified articles were country/region, year, type of study, type of procedure [open vs. video-assisted thoracoscopic surgery (VATS)], number of patients, cost, LOS and complication rates. **RESULTS:** The care path captured treatment events from diagnosis of nodules to post-surgical follow up care. PAL treatment options included the Heimlich valve, autologous blood patch or both prior to discharge. Eleven studies reporting cost data for 4,945 VATS procedures and 18,033 open procedures were identified. LOS [3.0 – 17.3 days (VATS) versus 5.0 to 23.8 days (open)], hospital costs [US unadjusted: $10,084 to $23,826 (VATS) versus $12,119 - $25,125 (open)] and complication rates were lower for VATS versus open procedures. Similar cost differences were reported in Korea, Japan and China. Post-discharge care and cost of patients with PAL were driven by the utilization of home health care, increased pain management costs, more frequent doctor visits and delayed return to work. **CONCLUSIONS:** There is wide variability in the care path options associated with management of PAL and associated complications during LVRS in emphysema patients. VATS appears to have a positive health care utilization and cost advantage versus open procedures globally. Further analyses are needed to quantify the true cost of care associated with managing PAL in LVRS patients.

PCN61

CABAZITAXEL IN SECOND LINE (2L) TREATMENT OF METASTATIC CASTRATION RESISTANT PROSTATE CANCER : AN ECONOMIC EVALUATION IN SWEDEN

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OBJECTIVES: To evaluate the cost-effectiveness of cabazitaxel in 2L metastatic castration resistant prostate cancer (mCRPC) patients who progressed after docetaxel (D) from the Swedish health care perspective in a subgroup of the TROPIC trial (NCT00417079) **METHODS:** A Markov cohort based cost effectiveness model was used. Transition rates between the health states representing mCRPC disease progression (stable, progression, death) were estimated based on progression of disease and survival rates from the TROPIC trial. The efficacy and safety data is based on the results of the TROPIC trial, which compares cabazitaxel plus prednisone to mitoxantrone plus prednisone in patients previously treated with docetaxel. Resource inputs were obtained from literature, hospital data and key opinion leaders. The subgroup is defined as those patients who initially responded to D but experienced disease progression <3 months since last D dose. At the time of the trial, the combination of Mitoxantrone (M) and Prednisone (P) was considered to be an appropriate second line comparator. Hence, in the base-case, M + P is the main comparator, in accordance with the TROPIC trial design. In addition, an indirect comparison versus P alone was carried out. Costs in added life years were added in the model to follow the societal perspective of Swedish health care system. **RESULTS:** In the base case analysis, total costs were estimated to be 699 176 SEK for Cabazitaxel, 320 491 SEK for M+P and 302 726 SEK for P alone. For the TROPIC subgroup, the ICER for C+P vs M+P was 943 270 SEK/QALY, ICER for C+P vs P alone was 990 903 SEK/QALY . Based on historical decision making by TLV, the threshold in Sweden is 1,000,000 SEK/QALY. **CONCLUSIONS:** Cabazitaxel appears to be a cost effective option compared with mitoxantrone and prednisone in the subgroup of TROPIC in Swedish health care setting.

PCN62

COST-EFFECTIVENESS OF POSACONAZOLE VERSUS FLUCONAZOLE/ ITRACONAZOLE IN THE PREVENTION OF INVASIVE FUNGAL INFECTIONS AMONG HIGH-RISK NEUTROPENIC PATIENTS IN SINGAPORE

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OBJECTIVES: To evaluate the cost-effectiveness of posaconazole versus fluconazole/ itraconazole in invasive fungal infection (IFI) prevention among patients with acute myelogenous leukemia (AML) or myelodysplastic syndromes (MDS) and at high risk of IFI due to chemotherapy-induced neutropenia in Singapore. **METHODS:** A decision-analytic model previously developed for the US and other countries was adapted to Singapore, to estimate the cost-effectiveness of antifungal prophylaxis with posaconazole compared to fluconazole/ itraconazole among AML or MDS patients at high risk of IFI. Patients were assumed to receive prophylaxis with posaconazole or fluconazole/ itraconazole. Probabilities of IFI, IFI-related death, and other cause death within 100 days of follow-up were estimated from clinical trial data. Trial results were extended to a lifetime horizon by modeling cancer-specific mortality, estimated from published sources, in one-month Markov cycles. Prophylaxis and IFI treatment costs were estimated using data obtained from two hospitals in Singapore. Model